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ABSTRACT

This booklet provides a guide for adults, parents, older siblings, and caregivers to help children develop constructive attitudes about present and future drug use. The first part of the guide focuses on role models in early childhood and implications of their behavior for children's future drug use, noting that parents, family, and the community need to recognize that children will copy their behavior. The second part focuses on competence and confidence, and how self-esteem, as a defense against habitual drug use, has a high influence on young children's attitude and skill development. The third part focuses on medicines as a child's first drug, offering suggestions to parents on using and storing medicines and on when to consult a doctor. (AP)

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The purpose of the Australian Early Childhood Resource Booklets is to provide a forum for the publication of Australian information which will be a resource to people interested in young children.

This booklet was funded by the National Campaign Against Drug Abuse

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FOREWORD

In producing this Resource Booklet which focuses on the broad heading of drug education for young children, the Australian Early Childhood Association has taken a new approach in its publication program.

The Association is most grateful to the Hon. Neal Blewett, Minister for Community Services and Health, for providing funding for this project under the National Campaign against Drug Abuse. The project included the production of four Today's Child Leaflets. We would also like to thank officers of the Drugs of Dependence Branch of the Department and in particular, Ms Cecily Stead, for their most valuable support and assistance.

I am sure that this publication will prove to be a very valuable resource for parents of young children and for professionals working with young children.

I would like to thank the authors who have contributed their time and professional expertise and the steering committees of the two publications for bringing this project to fruition.

Mrs Anne Murray
National President
Australian Early Childhood Association

DRUGS: A PREVENTIVE APPROACH IN EARLY CHILDHOOD

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INTRODUCTION

EARLY CHILDHOOD AND LEARNING ABOUT DRUGS

Rob Irwin

The conventional wisdom is that young children are not "into" alcohol and other drugs. That the converse is true, can be seen when the definition of a drug is considered. A World Health Organisation Memorandum defines a drug in the broadest sense as "... any chemical entity or mixture of entities other than those required for the maintenance of normal health, the administration of which alters biological function and possible structure". This definition would exclude food, water, oxygen, endocrine substances etc. in amounts required for the maintenance of normal health. (Commonwealth Department of Health, 1985, 1)

Children are clearly affected by drug use in our drug-using society. Consider the harm to children from drink driving crashes, and from the effect of side-stream tobacco smoke. Children's use of prescription and across-the-counter drugs, though for beneficial purposes, can be harmful if used unsupervised or inappropriately.

Learning to reduce harm

The National Campaign Against Drug Abuse strategy is focused on the harm from drug use. The aim is to minimise the harmful effects of drugs on Australian society. The campaign purposes of importance to young children are achieved through:

- "promoting greater awareness and participation by the Australian community in confronting the problems of drug abuse
- achieving conditions and promoting attitudes whereby the use of illegal drugs is less attractive and a more responsible attitude exists toward those drugs and substances which are both legal and readily available".

(Department of Health, 1985, 2)

As the drug use by young children is often at the behest of older children, older siblings, and influential adults, it is these people who have the responsibility for minimizing the harm in the Campaign strategy.

Guides to help children

The contributers to the Resource Booklet provide guides for these older people to help children cope with drug use, now and in their future. The three papers present the elements of drug use - the *substance* used, the *set* of the person using the substance, and the *setting* in which the substance is used. All papers consider these elements. For the reader, the particular emphasis of each paper could be considered with advantage.

Tessa McCallum in "Role Models in Early Childhood: Implications for Future Drug Use", has the focus on the setting of the child's drug use. In particular, the people environment, involving parents and the family setting, is considered.

Robyn Triglone in "Competence and Confidence" focuses on the person factors in drug use. Self esteem, as a defence against habitual drug use, considers the influences on young children's attitude and skill development.

Joan Costanzo and Leone Coper in "Your Child's First Drug" focus particularly on the substance. In particular, medicines for young children are the responsibility of parents as the caregiver.

Different approaches and perspectives

The complex range of factors in any drug use means that any approach to limit problems associated with the use of drugs requires coordinated actions over a considerable period of time. Readers may bring the elements of the three papers together for learning about young children's drug use.

Approaches to learning about drug use have been classifed into four models (Nowlis, 1975). In the traditional moral-legal, the medical or public health, the psycho-social, and the socio-cultural approaches different perspectives are held on how children learn to cope with the substance, set, and setting factors (Irwin, 1975, p.5) in drug use in their communities.

Resource papers the base for action

Considering social learning theory in the papers, and the need for accurate information, all the elements of drug use are important to young children's learning about drugs, and their own actions. As adults, seeking to minimize harm, these papers confirm for us that learning about drugs should be in the child's own context. This learning should not be seen as an event for, say, the pre-school. Learning about drugs should be viewed as a continuing process for children and adults. Parents and other adults responsible for the wellbeing of younger children have in these papers a resource to help them cope with their approaches to drug use.

Decisions about alcohol and other drugs in children's environments can be based on the information of *Your Child's First Drug*. The development of attitudes and values about drug use by children can be guided by the concepts in *Competence and Confidence*. The context factors for children's learning about drugs are given in *Role Models in Early Childhood: Implications for future drug use*. While adults have responsibility for the wellbeing of young children their actions regarding the development of attitudes and beliefs about drugs will be most important. I commend the avenues, suggested in this Resource Booklet, to all these adults.

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Part One

ROLE MODELS IN EARLY CHILDHOOD: IMPLICATIONS FOR FUTURE DRUG USE

Tessa McCallum

DRUGS AND SOCIETY

All societies, throughout history, have used drugs which alter moods, thoughts and feelings. (See Jaffe, 1985) Australia is no exception. We are a drug-taking society within which recreational use of drugs is seen as normal human behaviour and an accepted part of living. Drugs used in different societies at different times vary. In Australia the "acceptable" drugs are caffeine (in tea and coffee and some "soft" drinks), nicotine (in tobacco), analgesics (such as aspirin), and alcohol. Alcohol, particularly, has come to have a dominant role in contemporary Australian society. We no longer say "come and have a cuppa" - we say "come and have a drink". Our lifestyles and values sanction the use of the legal drugs, and in some groups some of the illegal ones as well. This sanctioning is reflected in very high consumption figures. (Kearney, 1985:20)

On the other hand, in a study conducted by Elliott and Shanahan Research, for the Drug Offensive's advertising campaign (1987), a general community attitude was found to be that "drugs" was the biggest problem facing young people today, followed by unemployment, and then alcohol. In the light of this community perception it is important to clarify two points: alcohol **is** a drug, and drug-taking is nothing new, and certainly not confined to young people.

Children growing up in a drug-taking society are not likely to abstain from drugs themselves. By the time they reach their teens most children today are thoroughly socialised to expect that drugs may be justifiably and acceptably used to give pleasure and reduce discomfort. They will naturally tend to model on the cultural patterns prevalent in the society in which they are nurtured.

It is becoming increasingly clear that the process starts at a very early age and that family and particularly parental influences are enormously important.

WHY DO WE CARE?

Most of us can continue to enjoy our cups of tea and coffee and our glass of wine with dinner and come to no harm. However, over-consumption of alcohol, nicotine, psycho-active drugs and food is probably the major contributing factor in most of the leading causes of illness and death in modern society. (Chesher, 1987) Smoking, in fact, is considered harmful in any quantity at all. This applies not only to the smoker, but also to those around the smoker, such as children, who are considered to be 'passive smokers' (U.S. Department of Health and Human Services, 1986). In the case of other drugs it is the *abuse*, rather than the *use* of any drug which can cause major health problems for individuals and major social problems for the community.

How do we know when drug use has become drug abuse? Chesher argues that the term "abuse" has not had objective definition - it remains a value judgement. Chesher's definition of drug abuse, to avoid value judgement, is the "use of a drug so as to constitute a threat to health" - physical health as well as social and economic well-being, for both the users and those around them (Chesher, 1987:5). Some individuals develop a dependence on a drug which makes them continue to use it in the face of seriously adverse social and medical consequences.

So where do we draw the line? If children's exposure to drugs is great, as it is in our society, how do we ensure that they will use drugs safely, or not at all? Much of the evidence suggests that it is what we do ourselves, as a community, as adults, as parents, that we see reflected in our children.

WHY EARLY CHILDHOOD?

Although the causes of drug-taking behaviour are both complex and not fully understood studies indicate that drug-related attitudes, beliefs and behaviour patterns are formed at a very young age. A study by Tennant (1979) revealed that preschool children had a considerable awareness of substance use and health-related behaviours, derived mainly

from parents and television. In many cases the children gave knowledgeable answers regarding the consequences of smoking, over-eating and alcohol consumption. Pratt *et al.* (1987) found that the cognitive level of 4 year old children does not limit their ability to learn basic health information.

Several important studies have shown further that preschool children with a family model of drinking and smoking were much more likely to smoke themselves or to intend to smoke. Eddy (1984), for example, conducted a study of 169 Australian preschool children aged between 4 and 6 which demonstrated that the preschool child's awareness of cigarettes and smoking behaviour was overwhelmingly influenced by a parent or close family member who smoked and where this was considered normal and acceptable in the home environment.

Children of parents who drink, also, have been shown to have greatly increased chances of themselves becoming drinkers. They have also been shown to have greatly increased risk of using other drugs. They have learned that the use of a drug is the adult manner of responding to pressure, stress or the desire for pleasure. Thus parents wishing to provide good role models for their children could choose an alternative response. For example, if Mum or Dad is stressed and has a headache, instead of reaching for the Scotch, coffee, cigarette or aspirin, they could (a) verbalise that they have a headache, (b) say what they are going to do about it, and (c) lie down, or sit quietly, or go for a walk, or listen to some music.

Although most children do not go on to use illegal drugs, those who do almost always start with tobacco and alcohol. A study by Baumrind (1985, cited in Krivanek, 1988) which followed children from their preschool years through to junior high school, replicated the general finding that use of substances acceptable to the community precedes the use of those that are disapproved.

Our major focus should therefore be on the legal and socially acceptable drugs, as these are by far the most commonly used in our society. Further, because health habits, including drug use, are formed early in life it seems logical to target preschool children in order to lay the foundations for the kinds of adult behaviour and lifestyles which we see as healthy. The preschool environment can play an important role here. Preschools can be smoke-free zones, and they can be places where positive messages are given out to children, such as 'Look after yourself. You're special'. These positive messages which enhance the "healthy self-image", promote the idea that the body functions well without drugs.

As Wragg (1986) found in his study of drug use amongst 11-12 year olds there is a very real need to counter powerful media images and community pressures which portray maturity as involving the use of alcohol and tobacco. Early childhood is the best time to develop responsible attitudes and behaviour in relation to drug use.

SOCIAL LEARNING

The theoretical framework for regarding drug use as a form of learned behaviour is Bandura's Social Learning Theory (Bandura, 1977). Bandura argues that behaviour is learned by modelling, through observation. Children learn large and integrated patterns of behaviour by vicarious observation. The language, lifestyles and institutional practices of a culture are taught to each new member of it by those who exemplify these cultural patterns (Bandura, 1977:12. See Kearney, 1985). In our culture, for children, these are primarily parents, but also the whole community. Bandura sees social learning as a dynamic interaction between the person, the person's behaviour and the environment.

Several studies have born out this theory. Grichting (1986), in a study of the general and student population in Queensland, looked at the relationship between the respondents' current drug use and

(1) their satisfaction with family life

(2) how much their mother and father drank when they were 8 years old

(3) how much the respondents' parents drink now.

Grichting found that past parental drinking behaviour emerged as the most important determinant among the three family variables under examination and that this modelling took place during "the early stage of socialisation" - when they were "about 8 years old" (Grichting *et al.*, 1986:92). In 1978 Kandel *et al.* reviewing family histories, noted that 82% of parents who drank had adolescents who also used alcohol, and that 72% of the parents who abstained had adolescents who abstained. (Other studies which confirm these results, and reach similar conclusions are cited in Mayer, 1986.)

NEGATIVE ROLE MODELS

An important aspect of the process of imitation is the perceived gain by the child from certain behaviour. Adults/parents not only transmit behaviour, but also the value attached to that behaviour. Thus children can associate parental drug use with positive or negative values. Most empirical work has related to adolescents, but Johoda and Crammond (1972, quoted by Casswell *et al.*, 1985) showed evidence of parental influence in a sample of children 4-10 years old when there was either abstinence or heavy drinking in the family. It was found that the attitudes of 6-10 year old children towards alcohol were mostly negative, and it suggests that these negative feelings are increased by the experience of alcohol-related problems in the family or close social environment. The study found that children of parents who drink more, but in a problem-free environment, have more positive attitudes towards alcohol (p.193).

A more recent study by Herberg (cited in Halebsky, 1987) found that when parental drinking behaviour was perceived as extreme, either abstaining or heavy, the imitations dropped off. These results are also supported by 1985 research by Friedman and Humphrey (cited in Halebsky, 1987) on 856 undergraduate students. The researchers found that personal experience with a family problem drinker reduced student drinking.

Clearly parental values and behaviours are more likely to be copied by children if the children see drug-use in their families in a positive light.

DRUG-TAKING AND FAMILY LIFE

A number of findings have shown a relationship between the general family environment and the use of drugs amongst adolescents. It has generally been found that a positive, loving bond between parent and child - especially the same-sex parent - is linked with reduced drug-use on the part of the child (Hundleby, 1987). Penderghast and Schaeffer (cited in Mayer, 1986) found a strong relationship between adolescent heavy drinking and lax parental control, parental rejection and psychological tension in the relationship with either parent. (See also other studies cited by Mayer, 1986)

Friedman (1985, cited in Halebsky, 1987) in a National Institute of Drug Abuse report, found that inconsistent limit setting, family dysfunction, lack of closeness between family members, and high amounts of disagreement between parents are all associated with high substance use by adolescents.

Krivanek (1988) links the development of social controls in children to the family, and where children had concerned, warm guidance which encouraged the development of personal, internal controls and values in children, there was less likelihood of drug abuse. These controls, she asserts, are established very early, possibly well before formal school begins.

PARENTS AND PEERS

Modelling from both parents (and other important adults) and peers obviously plays a major role in the development of attitudes to drug use. On the whole peers have a strong influence on lifestyles, while parents' influence is more strong on basic values and future life goals and aspirations (See Kandel, 1985:157). Further, peer influences are strong at adolescence but

tend to be relatively short-lived compared to the influences from parents, which can continue long past the early childhood years. (See Brook *et al.* 1980)

As Kandel sums it up: "To the extent that parents have an influence as definers and modelers, that influence is strongest at the early stage of drug involvement, preceding initiation. The most clear-cut instance of such a modeling effect is the impact of parental alcohol use and attitudes about alcohol on adolescent initiation into alcohol. Once drugs have been experimented with, however, parental influence asserts itself mostly indirectly through the choice of friends by the adolescent.... Once the use of either alcohol or marijuana has begun, imitation of peers is the dominant influence". (Kandel, 1985:158)

Some curiosity about and experimentation with drugs is normal and to be expected in our drug-oriented culture. Baumrind (cited in Krivanek, 1988) has found that adolescent experiment with substance-use in this society is neither statistically atypical nor developmentally abnormal (Krivanek, 1988:25). The processes of social learning - imitation and social reinforcement - are crucial. Behaviour is learned by observation and then displayed more often when it is approved by significant others. So, as Krivanek argues, even when adolescents are questioning parental and authoritarian influences they rarely reject parental values totally. Thus, in the case of drug use, they may imitate their parents by using drugs to relieve stress, etc., but still demonstrate their rebellion by choosing illicit drugs rather than the "acceptable" drugs their parents use. (See Krivanek, 1988)

Peers tend to become increasingly important influential models as time goes on. However, both peer and parent influences are often issue-specific and in a number of areas parents continue to exert a dominant influence for a very long time. Johnston (1985) found that when 25-year-old men and women who either abstained from marijuana or had stopped using it were asked why they did so, 60% of the abstainers and 53% of the quitters gave parental disapproval as the *main* reason. (Cited in Krivanek, 1988:22)

PRACTISE WHAT YOU EXPECT YOUR CHILDREN TO PRACTISE

The primary conclusion to be drawn from all of this is that parents and the community do need to recognise how much their children will copy them, and therefore to look at their own substance use. Because preschool children usually don't drink and smoke it is often hard for parents who do drink and smoke to see the link between their own behaviour and that of their children, and to see that the examples they present are likely to influence the *future* behaviour of their children.

Without advocating total abstinence, or promoting parental guilt, it is important to repeat that parents and the community need to practise responsible drinking and drug use if that is what they expect from their children. And the earlier in children's lives parents are aware of this the earlier the children will learn the behaviour their parents want from them.

Providing good role-models is no guarantee that children will never get into trouble, but it should reduce the chances. Conversely, early childhood influences don't necessarily imprison children in patterns of behaviour which they can never get out of. Children who are taught to think critically, to be aware of the issues and to develop good decision-making skills can make their own choices about drug-use which can help them alter the attitudes and behaviour which they may have learnt from their parents.

There is no magic bullet solution to the problems of drug abuse. Ultimately, perhaps, the community needs to examine its own fundamental values and its part in the modelling process. But within the family a first essential step is to encourage parents to provide a model of moderate and responsible alcohol use and to help their children to become thinking adults.

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Part Two

COMPETENCE AND CONFIDENCE

Robyn Triglone

INTRODUCTION

It may be that the strongest defence against falling victim to habitual drug abuse is the development of high self-esteem and the personal skills to cope with life's stresses and problems. If drug abuse becomes a problem it will probably be in adolescence or early adulthood, but the development of an individual's self image begins in early childhood. It is in these years that caregivers and teachers need to lay the foundations for high self-esteem and personal competence in individuals.

HIGH SELF-ESTEEM - A Definition

In its narrowest form self-esteem may be defined as the individual's knowledge of self. That is, their self-concept. If we are talking about *high* self-esteem then a knowledge of oneself certainly is important. However a broader description would also include:

a belief in one's basic worth

a realistic sense of control over life events

the personal skills to cope with stressful situations.

A Profile of a Child with High Self-Esteem

The following are the sort of characteristics you might expect to see in a child with high self-esteem.

- Expects to succeed - tries new things; says things like 'I can do that'; engages in problem-solving if unsuccessful and when necessary asks for help in order to learn.
- Expects to be valued - stands erect and looks directly at people; initiates interaction with new acquaintances; communicates needs in a manner that is accepted; is not constantly seeking reassurance, such as "Are you my friend?"
- Has good language skills in conflict situations - says what she/he wants; negotiates, is neither timid nor bullying.
- Makes decisions - exercises choices rather than waiting to be told.
- Enjoys interactions with others - smiles; talks to and attends to others; invites others to play.

High self-esteem is not an innately acquired personality trait. It is a vision of oneself that is developed over time as a result of the accumulation of life experiences. It comes about through interaction with others (particularly significant others) and with the physical environment. There are many ways in which caregivers and teachers can help to develop children's self-esteem.

HELPING CHILDREN DEVELOP HIGH SELF-ESTEEM

There are four main factors that are influential in the development of self-esteem.

Modelling - seeing high self-esteem in others and learning from them.

Autonomy - a realistic belief in one's ability to cope; to solve problems; to face day-to-day challenges. A feeling of *I can manage.*

Emotional Competence - the ability to recognise and to deal with one's feelings in a way that promotes the well-being of one's self and of others.

Praise - hearing positive messages from people who are important to us.

MODELLING

The Social Learning Theory (Bandura, 1977) recognises modelling as an important medium through which children learn. Those people most important to children are also the most influential. Caregivers, whether they mean to or not, teach children by their own behaviour. It stands to reason then, that parents and teachers who have high self-esteem are more likely to promote high self-esteem in the children in their care. The adult who doesn't have a robust self-image can't acquire it simply by making the decision to do so. Nevertheless, you can begin by giving yourself positive messages such as 'I am a good parent/teacher' and 'I am doing a good job'. The adult who has a strong sense of self-respect gives children permission to think well of themselves. The idea of guarding against saying anything that might give a child a 'swelled head' is a pernicious one and has no place in a programme on self-esteem.

AUTONOMY

People with high self-esteem see themselves as effective human beings. Of course people who believe that they have control over *everything* that happens to them may end up blaming themselves for events that are really outside their control. Such a belief is more likely to reduce than enhance self-esteem. However, what we want to avoid is a state of helplessness. Instead, the goal is for the child to develop a realistic sense of control and of competence.

A Sense of Control

It may seem that being able to control one's life is a long way down the track for a young child. But young children can begin to feel competent if they can put on their own jackets, tie their shoe laces or leave Mum without crying. Bigger achievements can wait. It is the *sense* of control that matters. The child who feels helpless depends on the outside world to make things better. At the moment that's probably Mum and Dad, but if that sense of helplessness continues into adolescence and the parents no longer have the answers... what then? Such individuals look for answers outside themselves. Sometimes this means turning to drugs such as alcohol. (Tanck and Robbins, 1974)

There are a number of ways in which adults can help children acquire the competence necessary for them to feel they have some control over their life events.

Cause and Effect

In order for children to learn that what they do has some effect, they need the opportunity to observe the relationship between their behaviour and its consequences. There are many times when it is better to resist the temptation to say 'It won't work that way' or 'Let me do it', and to look for opportunities to allow children to try for themselves. We know that last block will be enough to send the tower tumbling, but children need the first hand experience if they are to learn about balance, or about the feeling of having a tower fall down. If you throw the ball too hard it will go over the fence, but the only way to work out how hard is 'too hard' is to throw the ball and see what happens. Sometimes, of course, it is not appropriate to allow children to learn through consequences. For example, we don't allow children to play on the road and experience the consequences. It is always important to be conscious of children's level of development and therefore of how much responsibility they can take for their actions.

The difficult thing for parents is to be a support to their children and yet to know when not to stand between children and the adverse consequences of their actions. This is not an easy task, not just because the protective instincts of parents are involved, but because there are times when the consequences are just too dire for young children to handle. Nevertheless, the fine line between overindulgence and neglect has to be trodden if children are not to develop "misguided 'fictions' about life,... frequently in the form of feelings of inferiority and helplessness." (Lefcourt, 1980) When a favourite toy is broken through misuse it may be easier to buy another to avoid seeing the child upset, but it wouldn't help her/him make the connection between rough handling and broken toys and the disappointment that results.

When the school takes reasonable action in response to misconduct at school, blaming the school for lack of supervision or the 'bad company' the child keeps, may or may not be fair comment. But it won't help the child see the connection between the behaviour and its consequences. Discussing ways in which the child can behave differently, and thus avoid a repeat episode, is a more valuable learning experience. The message should not be 'What you did was wrong' but rather 'What you did had these consequences to yourself and other people. Let's talk about what you could do next time so that the consequences will be different'.

Making Decisions

For children to see the results of their actions they need opportunities to make decisions. Decision making skills need to be learned and they need to be introduced gradually by supportive caregivers. Children who are always told what to do, who don't get the chance to practice making decisions, are unlikely to suddenly acquire these skills in adulthood. If we wait until we are confident that children will make the same decisions that we would have made ourselves, it is not only too late but indicates a lack of trust. Often it is necessary for adults to positively look for opportunities to give children choices. In very young children it may be a case of choosing between buying a red or a pink T-shirt, or between having toast or cereal for breakfast. It is probably much easier to make these decisions for them, and many children would happily comply, but it would not enhance their decision-making skills. In preschool-aged children lots of choices can be made. For example, what to wear to preschool (no one cares if they wear a tutu!) or whether they want to go to gymnastics classes. A good rule of thumb is – *Is there a good reason for the child* **not** *to make the decision?*

Opportunities for decision-making in the early childhood centre abound. Young children can have choices about what they eat or what craft activities they do. For preschool-age children there is the opportunity for more sophisticated decision-making. It is important to mention here that a *laissez-faire* approach is not implied. Making decisions usually means working within limitations, not just doing what you want. Some of these limits children are able to place on themselves (e.g. 'I want that spade but I won't take it from Alice.'). I think it is also valid for teachers to become involved in the decision-making process (e.g.'I'd like you to choose to do drawing or blocks now because you have been in the homecorner for a long time and I think you should do other things as well.').

Group decision-making is also a possibility with children from about five on. It takes time, and some children find compromise more difficult that do others. Nevertheless, the patient teacher can help a group decide what they will do with a community project, what game they will play or what song they will sing. In doing so the pros and cons of the issues are canvassed so that children observe decision-making in progress.

It should go without saying that it is only really decision-making if the child's choice is accepted. Meaning 'Stay with Daddy, please' but saying 'Would you like to stay with Daddy?' can get you into hot water! It is important for children to know when they have a choice and when they don't. 'What colour will we make the flowers?' implies that the choice can be any colour. However, if the choice isn't accepted then children stop engaging in decision-making and spend their energies on trying to work out what answer the questioner wants to hear. If this is reinforced over time we are faced with adolescents who are more concerned with reflecting the opinions and life styles of others (namely their peer group) than in making choices that will benefit them.

As well as accepting children's decisions it is necessary for adults to support that choice. That is, having offered a child the choice because you are prepared to accept whatever decision is made, the caregiver must still be there to support the child. With young children it is often appropriate to allow them to change their minds, or it may be necessary to pick up the pieces when things go wrong. Again it is a matter of being aware of the level of development. On the one hand encouraging them to be responsible for their actions, at the same time providing the support and nurturing they need in order to be prepared to try again. It should be remembered that young children *practice* decision-making. They should not be expected to always make what adults believe is the right decision.

Children can also learn many of the skills of decision-making by hearing parents and teachers working through problems. Sometimes it is good to work through the problem with (or in front of) the child rather than just presenting the solution. This is particularly important if the adult feels she/he has to make the decision for a child. Rather than just presenting the child with a decision 'because I say so', caregivers can say how they came to that decision. For example, 'I know you would like to go and play with Mark and I trust you to stay in the yard. But I can't let you go because Mark's parents are not home. I thought about what would happen if there was an accident or if someone broke into the house. I think you are too young to bear that responsibility'.

Support in Facing Challenges

If children are to feel confident they need the support in a warm nurturing family environment. However, Crandall's research (1980, in Lefcourt) suggests that it is also important that children continually be encouraged to face new challenges. It is a case of adults having an attitude that implies they have confidence in the child. The message should be *I think you can do it and I'll support you in your efforts.* For example, when a child starts to climb, the temptation is to say 'Come down before you fall'. However, it may be more valuable to say 'Hold on tight. You're doing well'. When a child says 'I don't want to do this puzzle. It's too hard', working with the child offers support and encouragement. Doing the puzzle for him/her confirms the child's belief in their inability to do it. In supporting the child to face new challenges the caregiver should convey the message that it is O.K. not to get it right first time. For example, 'I know it's hard but let's just practice'.

It should be stressed that encouraging children to face challenges doesn't mean pushing them into tasks for which they are not yet ready. This is particularly important in our society in which academic achievement is valued even in the very young. This *pushing* is evident in the notion that children will benefit from early entry into school because it will put them ahead of their peers; and in the idea that the younger children are when they learn to read and write, the better. The result, however, is more likely to be failure (Elkind, 1986)or frustration (Ames, 1986), than success or confidence.

Problem-Solving

Facing day-to-day life is often very challenging. Having some problem-solving skills helps children in their academic development and in coping with crises. It is therefore important that young children be given the opportunity to think things through. A good example of problem-solving is that which can happen when children are engaged in box collage. We can tell children how to do it, or we can encourage them to come up with, and try, their own solutions. During block play we can tell them which blocks to use to bridge the span or we can discuss the distance involved and other considerations such as width, so that they can reach their own conclusions. Problem-solving is also important in the area of emotions. This is discussed under *Exploring Ways of Coping.* As with decision-making, children can learn to solve problems by observing significant adults solving problems competently.

Acquiring Skills

It is difficult to feel that you can manage if you can't! It is therefore very important that young children be given self-help skills. Sometimes this means adults recognising that although it feels good to be needed, children feel good when they can do things on their own. The acquisition of self-help skills such as dressing themselves, going to the toilet, blowing their noses, give a real boost to self-esteem.

In the early childhood centre children can learn to gather the materials they need (instead of having it placed in front of them), look after their own belongings, and tidy away what they have used. They can even do some of the washing-up! Such skills help children know that it is their centre and that they can manage without having an adult constantly at their elbow.

EMOTIONAL COMPETENCE

In order for children to feel that they can cope in difficult situations they need to be free of a sense of being at the mercy of their feelings. That is, they need to be able to control the behaviour that expresses their feelings rather than have their feelings dictate behaviour. This section deals with ways in which adults can help children feel in control.

Acceptance of Feelings

The first task is to recognise that feelings, once they have arisen, can't be controlled. *It is the behaviour that can be controlled.* Comments such as 'Don't be sad' or 'There's no need to get angry!' are futile. They don't make the feelings subside. In fact, they are more likely to make things worse by introducing guilt onto the scene because the child is unable to comply with such demands. Children, like adults, often feel better just by having their feelings recognised and legitimised. Try saying 'You really feel sad/angry about that, don't you?' That (and a cuddle) is sometimes all that is needed.

Part of the adult's role in accepting feelings is that of allowing children to express those feelings. When people are very sad they need to cry and 'big boys' are no exception. When people are angry they need to say they are angry and why. Telling little girls that such behaviour is 'not nice' only helps to raise their frustration and lower their self-esteem.

Once children accept that the feelings belong to them, they don't have the need to give them away, thereby avoiding taking responsibility for them. As adults we are often very good at this. For example 'You make me so angry'. Instead of saying 'I get angry when you do that; the message we give is that 'my anger is of your doing so I am not responsible for controlling it'. If however, we recognise that the feelings belong to us we have some hope of giving ourselves messages about coping with them.

Labelling Feelings

Those biological responses that are part of feelings are strange and sometimes frightening experiences for children. It is necessary to give them some language to use to express, and to think about, the way they are feeling. One way to do this is to supply them with a simple list of useful words such as *happy, sad, angry, proud.* Some useful activities for this:

Happy Circle - in which children talk about situations in which they feel happy. The circle can also be used for sad, angry and proud. At home parents can use times such as meal times to ask questions such as 'Did you do anything today that you feel proud of?'

Face drawing - pictures of people and their feelings (including explanations of why they are feeling that way).

Stories or picture talks - in which children are asked how they think the people in the pictures might be feeling.

Role Play - a simple game that involves making an angry/happy/sad face. This can be incorporated in a music session. Using appropriate music, children can be asked to walk like someone who is proud, angry and sad. It is interesting to observe which children are unable to express pride or anger. Such children will often show other signs of low self-esteem.

Another valuable way to help children acquire 'feelings' language is to provide them with models of adults who talk about how they are feeling. Sometimes we are so concerned with giving children a picture of self-control that we are reluctant to admit that we have strong feelings. For example, teachers sometimes say that they are sad to see a child throw sand in someone's face. What they really mean is that they feel angry. Perhaps angry seems too strong a term. However, not only is it better to give children the correct terminology, but it is an opportunity for them to see adults who are angry but not out of control.

Exploring Ways of Coping

Probably the most effective ways for children to learn to cope appropriately with their emotions is through the example of adults. For example, the parent who lashes out in rage when s/he becomes angry conveys the message that this is what you do when you feel angry. On the other hand, the child who sees adults expressing their anger or frustration by talking about how they feel and why, learn to act in a similar way. For example, 'I get so angry when you throw your food around that I *feel* like smacking you. But what I am going to do is leave you to eat on your own'.

Talking with children and exploring ways of behaving, is a valuable exercise. A possible approach might be to begin by helping a child identify an emotion either by word or facial expressions. Once the feeling has been given a name you can talk with the child about possible courses of action. For example, a child might *feel* like throwing a handful of sand. Without implying any guilt (there's nothing wrong with *feeling* like doing it) the adult can talk about the possible consequences of the action. Adult and child can continue exploring until a solution is reached that is socially acceptable and satisfying to the child. 'I can't let you throw sand because it hurts if it gets in people's eyes. What could you do instead?'

A word about grief. Deep feelings of sadness can be a part of a child's life just as it is an adult's. The approach that seeks to protect children from the sadder side of life can leave them in a vulnerable situation when the time comes. It is better to talk about sadness or grief as it arises so that the child recognises the validity of the emotion and understands that it will ease in time.

Learning to Ask for Help

Until now the discussion has centred around helping children look to their own resources in order to cope with life. However, no individual is completely self sufficient. Knowing when and how to ask for help is part of being able to cope. For example, sometimes children will become very upset because they need help such as in getting dressed. Such frustration is common in toddlers with little language and is to be expected. However, when older children can't ask for help that frustration can still be evident.

Parents need to be sensitive to their child's needs, but not always anticipating them. The child with parents who are sensitive to his/her needs knows that he/she can ask for help when needed. The child whose needs are always anticipated never has the experience of needing to ask. Lack of experience usually leads to a lack of skills.

Adults at home and in the early childhood centre do well to teach young children some basic phrases such as 'I need help', until such time as the language is better developed. Instead of automatically tying the shoe laces why not wait until asked? Not only do children need to know the words, but they need to know that it is alright to ask for help. A child might say 'I don't want to do that' when what is really meant is 'I can't do it. Will you help?'

When it comes to emotional needs it is even more important that children learn to ask to have their needs met. The child who can say 'I need a cuddle' has acquired a valuable skill. A cuddle is sometimes all that is needed to allay fears or provide that little bit of warmth that the child requires (for whatever reason). Other terms such as 'I want you to listen to me' or 'I want you to spend time with me' or 'I need to be alone' are also useful. How do children learn such phrases and when to use them? Having discovered the child's needs the adult can say "When you are feeling like that you can say 'I need . . . " If children find that such statements really have the required effect it will become part of their repertoire.

Another way in which children learn to ask for help is to see adults doing it. Of course, the adult who is excessively dependent will provide that model to the children in their care. But the adult who is self-reliant yet asks for help when needed gives children the permission and the skills to do the same. Try saying things like 'I'm feeling a little sad, will you give me a hug?' or 'I'm very busy, will you help me?' This can sometimes mean avoiding over-reacting to what in another situation would only be a minor irritation.

PRAISE

**The value of praise cannot be over-estimated.
It does, however, need to be used appropriately.**

Specific Praise

This is the sort of praise that tells children very clearly what they have done that you are pleased with. It is the praise that encourages appropriate behaviour, and should be a common part of the early childhood environment. Examples are numerous. 'Good! You're staying in your car seat', 'I'm glad you got ready so quickly', 'Thank you for helping clear the table', 'You sat so quietly during the story', 'You should be proud of yourself. You have worked so carefully on that drawing'. Each of these phrases tells the child exactly what it is you are praising. Terms such as 'Good girl' are not nearly as informative and make it difficult for the child to know what to do to be praised. We tend to think that the child always knows, but young children can be surprisingly unaware! It is an interesting exercise to ask children what they should do to be 'good'. The answers are not always what one might expect.

Sometimes punishments are necessary but these should also be specific, such as 'I'm sending you to your room because you hit Adam'. Terms like 'You naughty boy!' fail to tell the child what he has done that he shouldn't have, and it certainly doesn't tell him what to do to avoid punishment. It is also important to bear in mind that punishments should be kept to a minimum if children are not going to develop feelings of inferiority. Symptoms of severe anxiety may begin to develop if negative responses are not counter balanced by a reasonable number of positive responses. The proportion needs to be in the order of at least five positive responses to every negative response. (Kirkhart and Kirkhart in Cook and Armbruster, 1983)

Unconditional Praise

This type of praise has little to do with behaviour management. It simply tells the children that they are worthwhile and valued no matter what they do. For example, 'I love you so much', 'You're very special to me'. It is not enough to assume that your children know you love them. They need to be told. Caregivers may also be delighted to find how much they benefit from hearing children giving them positive messages in return.

SELF-ESTEEM AND THE CURRICULUM

While not dealing in detail with specific curriculum activities designed to enhance self-esteem, it is important to recognise that such activities are generally part of the program in any early childhood centre. For example, themes which centre on the child and her/his position in the family and society aim to give children a sense of identity and of belonging. Within this theme teachers often use activities such as body outlines, drawings of children and their families, drawings of things children enjoy or are good at, drawings depicting feelings. In short, drawings that children do about themselves. Discussion groups based on questions such as 'How are you feeling?' or 'What things do you do that you are proud of?' help children to get in touch with their feelings, and to give themselves positive messages. Teachers should also encourage children to try a full range of activities rather than only those activities that are typically 'male' or 'female'. By doing this they not only give children encouragement to develop and feel competent in all areas, they also help them to break out of gender specific stereotypes. Trying to live up to unrealistic stereotypes presents a real threat to self-esteem.

IN CONCLUSION . . .

People who are satisfied with themselves; who have the competence to make decisions and to cope with life's stresses, have little need to seek to escape into another world. Caregivers and teachers have an important role to play in assisting children to begin to develop these life skills from an early age. By modelling high self-esteem they encourage children to see themselves as valuable, and they offer examples of coping skills. By providing both challenge and support, by helping them to acquire self-help skills, problem-solving skills, and ways of dealing with their emotions, they develop competence. By giving children opportunities to practice decision-making and to see the connection between their actions and the ensuing consequences, they encourage children to regard themselves as having some control over what happens to them. By providing clear positive messages and a warm, accepting environment they encourage children to see themselves as valuable human beings.

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Part Three

YOUR CHILD'S FIRST DRUG

Joan Costanzo
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A DRUG IS A SUBSTANCE WHICH CHANGES THE WAY YOUR BODY WORKS

These days, most people know of drugs used for non-medical reasons (such as heroin, cocaine, opium, amphetamines, marijuana), and many of us have used legal 'social' drugs at some time or other (e.g. tea, coffee, cola, tobacco and alcohol). But there is another group of drugs which are used very widely by our society and, in fact, they will probably be the first drugs your child will use - MEDICINES.

Yes, they're drugs too, and whether they are prescribed for you or your family by your doctor, or you buy them without a prescription, they still need to be used extremely carefully. This is because drugs and poisons are very similar. In fact, in many cases, they can be exactly the same substance, the difference depending only on:

(a) the *amount* taken (the dose); and/or

(b) *the way* it's taken (e.g. a shampoo for lice can make a person seriously ill if it is swallowed instead of used on the skin).

This applies whether the drugs are based on plants and minerals which have been used for centuries (e.g. mercury, opium poppy, foxgloves), or are chemical compounds developed synthetically in the laboratory by a research chemist. Even up to 30 years ago, one medicine was often used to treat a variety of complaints. Nowadays, it's another ball game. Medicines are often very specific - which means they are designed to deal with just one complaint. If used correctly, they can be extremely effective. But if they aren't used according to instructions, there can sometimes be a risk that not only will the medicine be wasted, it may even become dangerous.

Still, don't let that stop you using medicines. They can be life-saving, particularly where young children are involved. At the very least, they can reduce the length, intensity and discomfort of an infection and can help avoid serious complications.

Every part of the body can be affected by drugs, which is one reason why medicines are such a powerful tool for making sick people well again. It's worth knowing however, that even though drugs can be given in certain ways, in a certain dose, to affect a certain organ, system, or region of your body, drugs often cannot "tell the difference" i.e. they can also affect other parts of the body besides the target area. This is why we sometimes get *side effects*.

The effect of a drug can be altered by other factors, e.g. body weight, general health, alcohol, and some foods (e.g. milk). The effect can also be altered by other drugs which may multiply, reduce, neutralise or even change its effects - hence the term "drug interactions".

It's the doctor's job to weigh up:

- what your child's health problem is and how serious it is
- any factors which need to be taken into account (e.g. age, weight, any special health problems, other medication, possible side effects) and to choose the treatment he/she thinks will deal with the problem most thoroughly and quickly.

But

- even if the doctor makes a perfect diagnosis and prescribes the most useful treatment
- and even if the pharmacist makes sure you get the right medicine and you know how to use it correctly
- the most important person in the curing process is the caregiver.

After all, the caregiver is the one who ends up with the responsibility for actually putting the treatment into action. This is why it is so important to know exactly what medicine you are using - and why; how to use it correctly; and how to store it so it doesn't lose its 'oomph'. This is

where your pharmacist (chemist) as well as your doctor can be really helpful. (After all, drugs - how they work, their side effects and possible interactions, how to look after them - are the pharmacist's specialty.)

MAKING MEDICINES WORK FOR YOU

Check it out

Questions the caregiver should be able to answer are:

1. What's the medicine's name?
2. What is it supposed to do?
3. How is it to be used and when?
   - Is it taken on a full or empty stomach?
   - Is it important to finish the course (e.g. antibiotics)?
   - Do I need to wake up the patient to take his/her medicine?
   - When is it O.K. to stop treatment?
   - If one dose is O.K., is double better - or possibly dangerous?
4. What foods, drinks, other medicines, or activities should be avoided?
5. Will there be any side effects? If so, what should I do about them?
6. If I miss a dose, what should I do?
7. Does it need special storage?

Storage

Just as carpentry tools need to be stored carefully if they are to do their job efficiently, health tools (medicines), need to be looked after too. It's hard to imagine an Australian home without at least one item dealing with health care - even if it is only a sticking plaster or an analgesic (pain-reliever). It is only too easy to imagine where some of these items are being kept - on the fridge, above the sink, by the bed, in various drawers and cupboards.

If we remember that medicines can be affected by light, temperature and/or humidity, it's easy to see why all medications (except those needing refrigeration), plus first-aid needs, should be stored in a special cupboard.

- THIS SHOULD BE CHILDPROOF AND KEPT LOCKED.
- It should have narrow shelves (not too many), to discourage hoarding.
- It should be in a cool, airy position, (a humid bathroom is *not* the ideal!)
- There should be good lighting both day and night to avoid selecting the wrong medicine.

The Home Medicine Chest

Basically, besides any current prescription medicines, a locked home medicine chest should contain:

- FIRST AID NEEDS such as plaster, bandages, tweezers, medicine measure, eye bath, etc.
- ANTISEPTIC for minor cuts and other skin damage
- MILD ANALGESICS for the occasional pain and fever (not aspirin for children under 15)
- CALAMINE LOTION for minor skin discomfort and, most importantly -
- IPECACUANHA SYRUP (to induce vomiting) and instructions for accidental poisoning
- A GUIDE TO FIRST AID.

EMERGENCY PHONE NUMBERS should be kept next to the phone. (e.g. Poisons Information Centre - See Emergency Services page inside the front cover of your telephone directory). And remember, when buying non-prescription items, only buy the pack size you need at the time. It's wasteful to buy anything larger.

Medi-Dump

Ideally, we should check the contents of our medicine chests *once a year.* This regular spring-clean is important because medicines do deteriorate over time - either they don't do the job anymore or, worse still, they can even become a health hazard.

As a general rule, throw out

- anything older than its expiry date (it's easy to check anything you're not sure about with your pharmacist)
- all prescription drugs not in current use; and
- eye and ear medicines over four weeks old.

Getting rid of unwanted medicines can be difficult, so don't even try. Instead, deliver them *yourself* - to your pharmacist. DO NOT give them to your children to deliver. DO NOT flush them down the loo. DO NOT throw them into the rubbish bin.

SETTING A GOOD EXAMPLE

Children are fantastic copiers.

- Leaving medication lying around;
- obviously popping pills yourself without any well understood medical reason;
- letting children help themselves to medication without supervision (whose drug will it be next time?);
- giving the child someone else's medicine (could be too strong for their body weight and might be for a different illness as well);
- offering rewards for taking medicine;
- making a fuss of medicine-taking children, especially in front of others.

None of these provide the best role model for children only too ready to learn.

And while we're on the subject, what sort of example is your use of other drugs? (e.g. alcohol, tobacco)

SICK CHILDREN

By the time a child is twelve she/he is likely to have had over sixty infections. Fortunately, however, most children's illnesses last only a few days, and are quickly resolved with rest, T.L.C. (Tender Loving Care), and time.

Some parents tend to race to the medicine chest at the first sign of discomfort. But ask yourself -

"Is it better to teach my child some useful self-management/survival skills?"

OR

"Is it a cop-out to depend on chemicals for minor physical or emotional discomfort?"

When faced with a sick child parents who say 'Yes' to both questions are more likely to:

- *drop their own hyperactive timetable* for a day or two;
- indulge themselves and their child in even more *warm fuzzies* than normal (cuddles and snuggles, crooning, reading favourite books, dozing together in a favourite spot);

- *reduce excess stimulation* from noise, bright light, extreme temperatures, emotional upsets;
- *stroke* their child's face or back *very* lightly with the fingertips, or do some *gentle massage*, or resort to the old *rocking chair*;
- teach their child *deep breathtaking:*
  - count as they fill their lungs from the tummy up
  - hold for half the time
  - let the air out slowly - again from the stomach up - for the same time as it took to fill up
  - hold for half the time
  - gradually increase the time.

  This helps reduce stress, controls discomfort and even pain and (last but not least!) diverts attention from the misery!
  (Marvellous for adults too.)

Unwell children find it hard to concentrate for long, so its kinder to everyone not to make too many demands. They may not eat well either. if appetite is a problem, in the short term, don't worry too much about nutrition, but offer favourite foods and drinks. The important thing is to keep up the child's fluids - at least one and a half litres a day.

In addition, the unwell child's room should have lots of fresh air. If there is no fever, and the weather is good, she/he can be let outside, however make sure infectious children are kept away from other people.

WHEN TO GO TO THE DOCTOR

Obviously, there are times when it is wise to see your doctor (general practitioner) such as:

- You are *unsure* what the problem is.
- The recommended treatment is *not working* or the child is getting sicker.
- The child refuses to *drink*.
- The child is unusually *drowsy* or irritable.
- A baby aged less than 6 months has a fever (any temperature above normal - 37°C or 98.4°F).
- A child has a fever of *38°C* (100°F) for more than 3 days.
- Fever measures over *39°C* (102°F) at any time.
- The child has abnormally *fast breathing*.
- There is *noisy breathing* especially if the tongue looks blue or the child can't speak.
- A baby aged *under 1 year* is *vomiting* or has *diarrhoea*.
- A child aged 1 to 2 years has *diarrhoea* for more than *24 hours*.
- *Vomiting*
  - is accompanied by *continued stomach pains* for more than 3 hours.
  - has gone on for over *twelve hours*.
  - is *greenish yellow*.
  - follows a violent coughing fit.

- The child shows signs of *dehydration* (watch for these when a child is vomiting or has diarrhoea).
  - more than ten runny motions a day
  - ten hours without passing urine
  - decreased skin elasticity (skin stays up a while when pinched)
  - drowsiness
  - baby's fontanelle (soft spot on top of head) is sunk in
  - sunken eyes or shadows under the eyes
  - rapid or slow breathing
  - very dry mouth and tongue.
- The child has a *rash.*
- The child has a *headache* which is not relieved by
  - removing physical, psychological, or environmental stress factors
  - massaging shoulders, neck, scalp, temples
  - cuddling and stroking
  - small dose of mild analgesic
  - sleep.
- The child has a headache
  - accompanied by fever, stiff neck, blurred vision, personality changes, or balance problems
  - after receiving a head injury
  - which keeps coming back with increasing severity
  - for more than a day
- The child has a *cold* with chest pain or yellow phlegm.
- There is *frequent passing* of urine.
- The urine is *burning, smelly* or changed in *colour.*
- There is *earache.*
- There is a tender or red area over *bone* in arm or leg.
- There are swollen *glands* (e.g. in the neck, under the arms or in the groin area).

NURSE-IN-CHARGE

As we all know, caring for children involves adults in taking on all sorts of important roles (e.g. nutritionist, educator, T.L.C. dispenser, psychologist, clown, etc., etc.). Not least of these is the NURSE-IN-CHARGE. This can be a bit frightening (especially with the first child!) Still, there are lots of useful backstops.

1. Get yourself a good book or two on childhood health and READ THEM - (preferably *before* any challenge to your knowledge level arises!)

   TRY

   - *Childhood medicines:* What they are and when to use them by Neil Buchanan. Doubleday, Sydney, 1987.
   - *Keeping Babies and Children Happy:* A parent's practical handbook to common ailments by Dr Bernard Valman. Methuen, Australia, 1985.
   - *A Home Guide to Diagnosing Illness: Children,* edited by Dr Christopher Brook. William Heinemann, Australia, 1986.

2. If you are starting to get worried, or can't remember all the warning signs, or need some reassurance about what to do next, use your pharmacist as a sounding board. It won't cost you anything and you will quickly know if you need to hotfoot it to the G.P., or whether you can handle things yourself.
3. Don't forget the clinic sister.
4. Family, friends and neighbours (you choose) can be great for moral support, or giving you time out.
5. Collect a set of Self Care Fact Cards from your Self Care pharmacist. There are over 50 topics to choose from including:

   - Gastroenteritis
   - Constipation
   - Headache
   - Threadworms
   - Relaxation Techniques
   - Diabetes
   - Immunisation
   - Nappy Rash
   - Common Cold
   - Head Lice
   - Asthma

   For the address of your nearest Self Care Pharmacy, contact your State's branch of the Pharmaceutical Society of Australia, or the National Office at PO BOX 21, CURTIN, ACT, 2605. Phone (062) 811366.

GOLDEN RULES

1. Drugs are potentially dangerous and need knowledgeable care if they are to work to our advantage.
2. Children are entitled to good role models so they can learn drug coping skills which will stand them in good stead.
3. If you're at all unsure about *anything* to do with medications .... ASK! ASK! ASK!

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